Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 8-21-01.
   b. The request was received on 8-2-02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60
   b. UB-92
   c. EOBs/Example EOBs
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. UB-92
   c. EOBs
   b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (4), the Division forwarded a copy of the requestor's additional documentation to the carrier on 9-9-02. The respondent did not respond to the additional documentation. It's initial response is reflected in Exhibit II.

4. Notice of Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Requestor: Letter dated 9-3-02:
   "(Provider) charges the above-referenced services at a fair and reasonable rate. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services. Based upon the requirements of Texas Administrative Code Section 130.304, a methodology may be developed to establish that a 'fair and reasonable' reimbursement amounts to ensure proper payment by Workers' Compensation Carriers…. The most common CPT codes utilized by (Provider) involve treatment, services and supplies that do not have a maximum allowable reimbursement (MAR). Therefore, (Provider) made an extensive

review of payments and reimbursements made by various Carriers from the geographical area of Texas for treatment, services and supplies utilized for both work-related and non-work related injuries…. As a result of that review, (Provider), was able to determine the usual amounts reimbursed by Carriers for treatment, services, and supplies from (Provider) for both work-related and non-work related treatment in the state of Texas at their facility."

2. Respondent: Letter dated 8-12-02:
"(Carrier) reimbursed the requestor $10,998.40 on 10-17-01, check number 5579409 based on a fair and reasonable audit done by (Audit Company). Every charge on the itemized statement was considered and the audit report listed any reductions and the reason for the reduction. The total amount owed per the F&R Audit was applied by paying the first line item of the first UB-92 at 100%, and every line thereafter at 100% until the total amount owed was paid….(Provider) never called to inquire on any specific item that was reduced. Their bill included in the MDR request is in a different format than the e [sic] original bill which (Carrier) processed for payment."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 8-21-01.

2. The carrier denied the billed services reflected on the EOB as, "M – PAYMENT BASED UPON ATTACHED COPY OF FAIR AND REASONABLE AUDITED TOTALS."

3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier $17,480.53 for services rendered on the date of service in dispute above.

4. Per the Requestor's Table of Disputed Services, the Carrier recommended payment in the amount of $10,741.38.

5. The amount in dispute according to the Table of Disputed Services is $6,602.95.

6. The services provided by the Requestor include such items as anesthesia and lab services, pharmaceutical products, medical and surgical supplies, sterile supplies and EKG.

V. RATIONALE

Medical Review Division's rationale:

The UB-92 indicates the services were performed at an outpatient/ambulatory surgical center. Pursuant to Rule 133.307 (g) (3) (D), the requestor must provide "…documentation that discusses, demonstrates and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement …."

The carrier, according to their denial on the EOB, asserts that they have paid a fair and reasonable reimbursement, and has submitted a methodology to support its reimbursement Per

Rule 133.304 (i), "When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall:

1. develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement;

2. explain and document the method it used to calculate the rate of pay, and apply this method consistently;

3. reference its method in the claim file; and

4. explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement."

The response from the carrier shall include, per Rule 133.307 (j) (1) (F), ".... if the dispute involves health care for which the Commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code 413.011 and §133.1 and 134.1 of this title;".

Due to the fact that there is no current fee guideline for ASCs, the Medical Review Division has to determine, based on the parties' submission of information, who has provided the more persuasive evidence. The Respondent has described their methodology for payment. Respondent utilizes a database that contains fees from over half of the nation's hospitals. This database allows the carrier to track billing trends throughout the nation. A universal chargemaster creates a common language linking one facility's chargemaster to another so that service and supply fees can be compared locally, statewide and nationally. The information obtained through the (Carrier's) chargemaster is validated through a multi-layered system of quality checks, which is refreshed each month. Review begins at the geographical zip code and expands to the area within the state where the provider is located. This review process allows for comparisons to be measured against actual charges of other hospital fees.

The requestor, as the health care provider has the burden to provide documentation that "…discusses, demonstrates, and justifies that the payment being sought is fair and reasonable rate of reimbursement…." pursuant to TWCC Rule 133.307 (g) (3) (D). The requestor has included in their packet example EOBs. Only one of the EOBs was able to be utilized for review process. No **additional** reimbursement can be recommended as the documentation noted in the dispute packet does not adequately discuss, demonstrate, and justify that the billed amount represents a fair and reasonable charge. Therefore based on the evidence available for review, the Requestor has not established entitlement to additional reimbursement.

REFERENCES: The Texas Workers' Compensation Act & Rules: Sec 413.011 (d); Rule 133.304 (i); Rule 133.307 (g) (3) (D), and (j) (1) (F).

The above Findings and Decision are hereby issued this 01st day of April 2003.

Lesa Lenart
Medical Dispute Resolution Officer
Medical Review Division

LL/ll